

# Care Quality Commission

## Inspection Evidence Table

### Avenue Surgery (1-556469798)

Inspection date: 27 November 2019

Date of data download: 22 November 2019

## Overall rating: Requires improvement

We rated the practice as requires improvement overall because we found the practice had not established effective systems or processes to ensure services were fully effective and well led.

### Effective

### Rating: Requires improvement

We rated the practice as requires improvement for providing effective services because:

- The practice did not have proper oversight of patients who had been exception reported to ensure records were accurate.
- Uptake for national screening programmes was below the national target. Improvements had not been identified.

#### Effective needs assessment, care and treatment

**Patients' needs were not always assessed, however care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant	Y

digital and information security standards.

Explanation of any answers and additional evidence:

The practice was unable to give formal assurances that all patients diagnosed with diabetes received effective monitoring of their care and treatment. For example, the practice achievement rates for patients diagnosed with diabetes, whose blood pressure was in an acceptable range, was below local and national averages. We saw evidence that this had been discussed at a clinical meeting, however the practice was unable to provide an action plan to improve and ensure effective monitoring, increase QOF scores and reduce exception reporting rates. We discussed this with staff on inspection and they were unable to identify how they planned to improve.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHSBSA)	0.81	0.81	0.74	No statistical variation

## Older people

## Population group rating: Good

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- A clinical pharmacist funded by the local clinical commissioning group carried out structured annual medicine reviews for older patients registered at the practice.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

## People with long-term conditions

## Population group rating: Requires Improvement

### Findings

This population group was rated as requires improvement due to concerns identified relating to low achievement of diabetic annual reviews and high exception reporting rates. However, there were areas of good practice.

- Patients with long-term conditions were offered a structured annual review to check their health and medicine needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding

care delivery for patients with long-term conditions.

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	77.6%	82.5%	79.3%	No statistical variation
Exception rate (number of exceptions).	17.4% (137)	16.6%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	60.4%	78.8%	78.1%	Variation (negative)
Exception rate (number of exceptions).	20.2% (159)	13.0%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	83.2%	81.8%	81.3%	No statistical variation
Exception rate (number of exceptions).	22.3% (176)	17.2%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	81.3%	76.2%	75.9%	No statistical variation
Exception rate (number of exceptions).	17.0% (144)	8.3%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a	94.6%	91.4%	89.6%	No statistical variation

healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	19.7% (50)	12.8%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)	83.2%	84.1%	83.0%	No statistical variation
Exception rate (number of exceptions).	7.1% (144)	4.9%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF)	93.9%	92.8%	91.1%	No statistical variation
Exception rate (number of exceptions).	3.6% (11)	5.7%	5.9%	N/A

#### Any additional evidence or comments

We discussed areas of low uptake of health reviews and high exception reporting with the practice's QOF lead on inspection. The practice could not demonstrate that they had effective oversight of exception reporting. They told us that the exception rates could be attributed to errors in coding. However, they did not provide an action plan to mitigate this risk and explain how exception reporting rates could be improved. On inspection, we identified that patients were exception reported part way through the QOF year after they had received the maximum number of invite letters. On a number of occasions, we identified that after patients had been exception reported, they had received a review of their care and treatment. The exception code had not been removed from their record. This meant that the practice did not have clear oversight of the number of patients who had received the necessary review and those who were still outstanding.

## Families, children and young people

## Population group rating: Good

### Findings

- The practice had met the minimum 90% target for all four childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.

- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	83	89	93.3%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	90	95	94.7%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	89	95	93.7%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	89	95	93.7%	Met 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information:  
<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

## Working age people (including those recently retired and students)

## Population group rating: Requires Improvement

### Findings

We rated this population group as requires improvement as cervical screening rates were below the national target and there were limited plans in place to improve uptake. However, we did see areas of good practice.

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	76.0%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	77.3%	75.1%	72.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	59.8%	61.5%	57.3%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	48.5%	71.3%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	45.9%	53.9%	51.9%	No statistical variation

#### Any additional evidence or comments

The above data relates to the Avenue Surgery prior to their merger with St Peter's Road Surgery. The information provided below includes data following the merger between the two practices in July 2018.

The practice was aware that uptake for cervical screening was below national targets. The practice was unable to evidence that they had identified ways to improve. They advised that there were six clinicians able to conduct cervical screening. Staff interviewed on inspection advised however that they were unable to offer screening appointments outside of core hours. Following inspection, the practice confirmed that patients were able to access appointments outside of core hours on two evenings a week.

We reviewed unverified Public Health England data for 1 April 2018 to 31 March 2019 which showed;

- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period within 3.5 years for women aged 25 to 49 was 74.6%.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period within 5.5 years for women aged 50 to 64 was 77.1%.

On inspection we reviewed unverified QOF data for 1 April 2019 to 27 November 2019 which showed;

- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period within 3.5 years for women aged 25 to 49 was 73.5%.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period within 5.5 years for women aged 50 to 64 was



82.6%.

Following inspection, the practice sent us additional unverified data for the 2019/2020 QOF year which showed cervical screening rates had improved and had been recorded as 76.8% and 85.6%.

### People whose circumstances make them vulnerable

**Population group rating: Good**

#### Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

### People experiencing poor mental health (including people with dementia)

**Population group rating: Requires Improvement**

#### Findings

This population group was rated as requires improvement due to concerns identified relating to high exception reporting. However, there were areas of good practice.

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and	94.6%	90.9%	89.4%	No statistical variation

other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	21.1% (15)	16.3%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	96.1%	91.9%	90.2%	No statistical variation
Exception rate (number of exceptions).	28.2% (20)	14.5%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	86.5%	86.8%	83.6%	No statistical variation
Exception rate (number of exceptions).	14.3% (21)	7.3%	6.7%	N/A

### Any additional evidence or comments

We discussed areas of high exception reporting for mental health indicators with the practice.

The practice had recently changed their process for exception reporting patients diagnosed with Dementia. It had been agreed at a clinical meeting in November 2019 that patients living with dementia who were housebound or those newly registered, should not be exception reported on that basis. The practice's exception code reporting policy was updated to reflect this. The practice also conducted a search of patients who had been exception reported since April 2019 to ensure this had been done appropriately.

### Monitoring care and treatment

**The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.**

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	548.9	No Data	539.2
Overall QOF score (as a percentage of maximum)	98.2%	No Data	96.4%
Overall QOF exception reporting (all domains)	8.6%	No Data	No Data

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	N



Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

The practice conducted an audit in November 2019, following a complaint from a patient. The audit looked at the prescribing of anti-inflammatory medicines to ensure it was done in line with best practice guidance. The practice looked at all patients prescribed these medicines who were in the at-risk age group who had not been co-prescribed other risk mitigating medicines. The search identified 18 patients where further action was required in order to bring their prescribing in line with best practice. A letter was sent to each patient advising that a review of their medicines was required. The practice planned to conduct a second audit in six months' time to review improvements made.

### Effective staffing

**The practice was unable to demonstrate that all staff had the skills, knowledge and experience to carry out their roles.**

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Partial
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	n/a
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: Not all staff had received safeguarding training appropriate to their role and in line with national guidance. For example, reception staff had completed children safeguarding level one training. This was not in line with the intercollegiate guidance which states that level two children safeguarding training was the "minimum level required for non-clinical and clinical staff who, within their role, have contact (however small) with children and young people, parents/carers or adults who may pose a risk to children."	

### Coordinating care and treatment

## Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y

## Helping patients to live healthier lives

### Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	96.6%	94.9%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.7% (25)	1.0%	0.8%	N/A

## Consent to care and treatment

**The practice always obtained consent to care and treatment in line with legislation and guidance.**

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y

## Well-led

## Rating: Requires improvement

We rated the practice as requires improvement for providing well led services because:

- Responsibilities, roles and systems of accountability to support good governance and management were not always embedded.
- The practice did not have clear and effective processes for managing risks.
- The practice did not always act on appropriate and accurate information in relation to exception reporting and MHRA alerts.

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at all levels.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y

### Vision and strategy

**The practice had a clear vision but it was not always supported by a credible strategy to provide sustainable care.**

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: The practice had formulated a business plan for 2019/2020 which identified areas for review. This included a review of the premises insurance and medical indemnity. However, it did not review how the practice intended to move forward and further integrate the main site with the branch location.	

### Culture

**The practice had a culture which drove high quality sustainable care.**

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Partial
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	
The practice was accredited as part of the workplace well-being charter. They held an annual Christmas event for all staff to attend.	
The practice had not effectively identified risks which could impact on staff.	

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
CQC staff questionnaire	Feedback from staff included that the management team were open and transparent.
Staff interviews	Feedback from staff included that they did not always feel involved or given enough information.

## Governance arrangements

**Responsibilities, roles and systems of accountability to support good governance and management were not always embedded.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
Systems to ensure policies and procedures were reviewed in a timely manner were not always effective. When we inspected in November 2019 not all policies and procedures had been reviewed since the merger in July 2018 to ensure all staff were working from the same process. For example, booking locum clinicians. When we discussed this with staff, they were unsure if there was a plan to integrate this process. We discussed this with the practice	

and were told that they had not identified a timeframe in which to complete these reviews. Following inspection, the practice sent us a policy review schedule however, this did not evidence when the process for booking locums was due to be reviewed.

Oversight of staff training did not ensure staff received training in line with national guidance. For example, not all staff had completed safeguarding training at a level appropriate to their role.

Practice policies did not always contain appropriate information in line with guidance. For example, the practice's safeguarding policy did not reflect the appropriate levels of safeguarding training required of staff in line with the national intercollegiate guidance.

The practice did not have effective systems to ensure complaints were responded to in line with practice policy and national guidance. No reference was made to the Parliamentary and Health Service Ombudsman in the practice's final response to complaints should the patient be dissatisfied with the outcome. Not all complaints received an acknowledgement before the final response or received notification when the final response would be received outside of the practice's timeframe. This was not in line with practice policy.

Practice systems to ensure staff had the necessary authorisations to administer medicines were not embedded. We identified eight out of 27 patient group directions (PGDs) at the branch location were not signed and authorised in line with guidance. For example, some staff had signed the PGDs after they had been authorised. (PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber.)

## Managing risks, issues and performance

**The practice did not have clear and effective processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: The practice had effective systems to conduct disclosure and barring service (DBS) checks for necessary staff. They had identified that all clinical staff and all non-clinical staff who acted as a chaperone, should receive a DBS check. The practice advised that non-clinical staff who did not conduct chaperone duties, would not require a DBS check. However, this had not been risk assessed in line with guidance.	



The practice did not have effective systems to identify and mitigate risk. Processes to identify risk were not consistent across both the main site and branch location. For example;

- Processes to identify risks relating to health and safety were not fully effective. The risk assessments conducted for both sites did not identify all potential risks.
- Processes to mitigate risk relating to legionella were not embedded or consistent across both locations. We saw that water temperature checks were not conducted for the main site in accordance with their risk assessment. We saw evidence that while water temperature checks were conducted for the branch location, they were carried out every two months which was not in line with the practice risk assessment. Following the inspection, the practice sent us evidence that they had introduced a document to record water temperatures at the main site.
- Processes to identify and mitigate risks relating to fire were not always embedded. The fire risk assessment for the branch location had identified that doors did not open in the direction of travel. No mitigation for this had been recorded. The risk assessment for the main site identified that not all fire doors were appropriately labelled, and some were propped open. Mitigation was given on the risk assessment for the practice manager's door to be open. However, no mitigation was identified to address other doors propped open and there was no action plan to improve the labelling of fire doors.

## Appropriate and accurate information

### The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice did not have effective oversight of the number of patients who had been appropriately exception reported. We identified patients were still exception coded despite having received the necessary monitoring. The practice was therefore unable to evidence that they had a clear understanding of who still required the necessary monitoring in order to identify areas for improvement.</p> <p>Practice oversight of patients prescribed sodium valproate was not embedded. We reviewed the practice's system for receiving and acting on Medicines and Healthcare products Regulatory Agency (MHRA) alerts. The repeat alert issued to providers on the prescribing of this medicine had been reissued in December 2018. There was no evidence that this had been recorded or acted on by the practice. On inspection, we were told that the clinical pharmacist conducted an annual search to determine if any patients prescribed this medicine fell into the at-risk category. We requested evidence to support this. The evidence obtained on inspection identified that there were three patients in the at-risk group prescribed this medicine. While it was identified that these patients had received appropriate monitoring, the practice was unable to show that these patients had been discussed at a practice level to support learning and awareness. Following inspection, the practice sent us clinical meeting minutes from April 2018 which showed that the prescribing of sodium valproate had been historically discussed. However, no up to date meeting minutes were provided.</p> <p>In July 2018 the Avenue Surgery merged with St Peter's Road Surgery to form The Cirencester Health Group. The provider's registration with CQC has been partially updated. At the time of inspection, no</p>	

applications had been received to update the name of the provider.

## Engagement with patients, the public, staff and external partners

**The practice involved the public, staff and external partners to sustain high quality and sustainable care.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: Since the Avenue Surgery merged with St Peter's Road Surgery, both patient participation groups (PPG) had integrated to form one patient feedback forum. The practice worked with their PPG to gain feedback on ways they could improve and on changes due to be implemented. For example, we saw evidence that the change in appointment booking system was discussed with the PPG. We also saw that the PPG was consulted on ways to reduce the number of patients who did not attend for their appointments.	

## Continuous improvement and innovation

**There were systems and processes for learning, continuous improvement and innovation but these were not always embedded.**

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: The practice was unable to demonstrate that they used data from the quality and outcome framework (QOF) to help drive improvement. Concerns relating to the practice's process for exception reporting had been raised at their previous inspection in 2016. QOF data for 2017/2018 showed that the practice were outliers for exception reporting in several indicators. No improvements were identified in the 2018/2019 QOF data. At our inspection in November 2019 the practice could not give assurance that they had identified actions to improve.  The practice told us that they planned to implement an urgent care team to deal with on the day patient demand. They hoped to have this in place by April 2020.	

## Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

## Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.